TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Igor Rakovchik, D.O.

Respondent Name
Vigilant Insurance Company

MFDR Tracking Number
M4-16-3391-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another. You will note in the attached narrative report and testing results all required and billed components were performed and documented appropriately utilizing the above TDI-DWC Fee Guidelines and should not be reduced … Please note that an office consultation was performed and documented as part of this date of service and should not be bundled or compounded per the CPT Codes as applied to this date of service."

Amount in Dispute: $272.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel asserts that the requesting party listed on the DWC-60 form is not an eligible party to medical dispute resolution pursuant to Rule 133.307(b)(1-5). Genesis Medical Management Solutions is not the health care provider that rendered the services in dispute. Genesis Management Solutions is contracted with the health care provider as its agent. As such, dismissal is requested for failure of an eligible party to request medical fee dispute resolution in accordance with division rules …

CorVel finds that the requestor's EMG report fails to support a high level office visit as separately occurring … A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 21, 2015	Evaluation & Management, new patient (99204)	$247.70	$0.00
December 21, 2015	Needle Electromyography, (95886)	$0.00	$0.00
December 21, 2015	Nerve Conduction Studies, 9-10 studies (95911)	$0.00	$0.00
December 21, 2015	Electrodes, per pair (A4556)	$25.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines terms related to medical benefits.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   Per Explanations of Benefits dated January 29, 2016 and May 2, 2016, submitted by the requestor:
   - P14 – Pymt is included in another svc/proc same day
   - 234 – This procedure is not paid separately.
   - RG4 – Service is incidental per Medicare Guidelines
   - W3 – Appeal/Reconsideration

   Per Explanation of Benefits dated January 27, 2016, submitted by the insurance carrier:
   - 234 – This procedure is not paid separately.
   - P14 – Payment is included in another svc/procedure occurring on the same day
   - RG4 – Service is Incidental per Medicare Guidelines
   - Comment: Provider was referred for testing only. No treatment will occur

Issues

1. Is Genesis Medical Management Solutions eligible to request medical fee dispute resolution?
2. What are the services in dispute?
3. What are the applicable rules for this dispute?
4. Is Vigilant Insurance Company's reason for denial of payment for procedure code 99204 supported?
5. Is Vigilant Insurance Company's reason for denial of payment for procedure code A4556 supported?

Findings

1. Vigilant Insurance Company asserted in its position statement that Genesis Medical Management Solutions (Genesis) is not an eligible party to medical dispute resolution because Genesis is not the health care provider, but rather is "contracted with the health care provider as its agent." The DWC060 identifies the requestor as the health care provider. 28 Texas Administrative Code §133.2(2) defines an agent as:

   > A person whom a system participant utilizes or contracts with for the purpose of providing claims service or **fulfilling medical bill processing obligations** [emphasis added] under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to "agent" as used in the term "pharmacy processing agent."

   Because an agent of the health care provider has the authority of fulfilling medical bill processing obligations, the division finds that Genesis has the authority to request medical fee dispute resolution on behalf of the health care provider, Igor Rakovchik, D.O.

2. Dr. Rakovchik included procedure codes 99204, 95886, 95911, and A4556 on the Medical Fee Dispute Resolution Request (DWC060). Dr. Rakovchik is seeking $0.00 for procedure codes 95886 and 95911. Therefore, these services will not be considered in this dispute. Dr. Rakovchik is seeking $272.70 for procedure codes 99204 and A4556. These services will be reviewed in accordance with applicable rules and guidelines for this dispute.

3. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

   > for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

4. Vigilant Insurance Company denied disputed procedure code 99204 with claim adjustment reason code P14 – "Pymt is included in another svc/proc same day," and argued that the narrative report "report fails to support a high level office visit as separately occurring." The division finds that procedure code 95911, billed by Dr. Rakovchik on the same date of service, has a global status of "XXX." Chapter I of the General Correct Coding Policies for *National Correct Coding Initiative Policy Manual for Medicare Services*, section D, states, in relevant part:

   > Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code … **With <u>most</u> "XXX" procedures, the physician may, however perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code** [emphasis added]**.** This E&M service may be related to the same diagnosis necessitating the performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. **Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding** [emphasis added].

   Review of the submitted documentation does not find that Dr. Rakovchik appended modifier 25 to procedure code 99204 in the billing process, signifying that the service was a significant, separately identifiable evaluation and management service. Therefore, Vigilant Insurance Company's denial reason is supported. Reimbursement for this service cannot be recommended.

5. Vigilant Insurance Company denied disputed procedure code A4556 with claim adjustment reason codes 234 – "This procedure is not paid separately," and RG4 – "Service is incidental per Medicare Guidelines." The division finds that CPT Code A4556 is a Bundled/Excluded code, which means:

   > There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.--If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

   The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." The electrodes are incident to the physician services furnished the same day, therefore, they are bundled in those services. Vigilant Insurance Company's denial reasons are supported. Reimbursement for this service cannot be recommended.

<u>Conclusion</u>

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 2, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.